HOFSTRA NORTHWELL SCHOOL OF MEDICINE AT HOFSTRA UNIVERSITY
RELEASE OF MEDICAL RECORDS FORM

Email completed form to: EHS@NORTHWELL.EDU

Student Name: Date of Birth:

Previous Name, if applicable:

Address:

City: State: Zip Code:

Phone Number: ( ) Email Address:

SAMPLE

1st Year Screening at EHS

- Physical Exam
- TB Screening/ Chest X-Ray
- Laboratory Results *(Titers: Measles, Mumps, Rubella, Varicella & Hepatitis B)*
- Respirator Fit Testing
- Ishihara Color Vision Test
- Vaccinations *(Tdap, Varicella, MMR, Hepatitis B)*
- 8 panel oral swab or urine drug screen

Annually

- TB screening
- Respirator Fit Testing
- Flu Vaccination

Optional

- 10 panel drug screen (3rd year rotations)

1. **Please check all documents you are requesting.**
   Please Note: You will receive the most recent information unless otherwise specified.

- ☐ Physical Examination
- ☐ Laboratory Results
- ☐ Drug Screen Results
- ☐ Immunization Records
- ☐ X-Ray Results
- ☐ Tuberculosis Screening Tests
- ☐ History/Old Records
- ☐ Other (specify)____________________

2. **Method of Delivery:**

- ☐ Mail - Anticipated delivery time of 10 to 14 days
- ☐ Pick Up - Can only be picked up by the student.
  If not picked up within 7 days, records will be mailed.
- ☐ Email - Will be sent to your Hofstra or Northwell Health email address.
  Records will be mailed if you do not include an email address.

This authorization is effective until requested documents have been released.

By signing this authorization form, you authorize the disclosure of your health information as described above. This information may be redisclosed if the recipient described on this form is not required by law to protect the privacy of the information.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to Employee Health Services, Northwell Health, 410 Lakeville Road, Ste 206, New Hyde Park, NY 11042.

____
Student Name (print)

____ ________________________________
Student Signature Date

FOR OFFICE USE ONLY

Employee Health Services Quality Assurance

EHS Staff member to use a two person check process for identity validation below.
If your EHS Office is a single staffed office, quality control checks should happen at least 5 minutes apart and can be initialed by the same staff member.

Initial________I have checked the release of this record (via name, DOB, address, or other means) and confirmed that the record being released is the correct record as per the above request.

Initial________I have checked the release of this record (via name, DOB, address, or other means) and confirmed that the record being released is the correct record as per the above request.

EHS STAFF ONLY
Date Processed: ________
Initials: ________

Revised 2/2/17